Living Well with Loss in Later Life

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The concept of living well with loss in later life is consistent with contemporary, critical perspectives on ageing. Such perspectives challenge traditional notions of ageing as problematic and burdensome and support the growing awareness of older people as assets and contributors to the societies in which they live [1, 2]. They also challenge us to understand more fully the nature of losses over the life course and their consequences in later life and, in so doing, to identify more effective strategies for countering them and enhancing quality of life as we age. Within that context, this chapter has three aims: to explore contemporary understandings of loss and grief over the life course, to examine how these can contribute to improvements in outcomes for older people and to identify the implications for practice.

3.1 Loss and the Life Course

Human lives are shaped by a diverse range of factors, some of which are relatively fixed (e.g. gender, ethnicity) whilst others may change over the life course (e.g. health and disability, socio-economic status, sexual orientation), with the physical environment, economic upheavals and social change also having cumulative effects in later life [3–5]. Grief is commonly seen as the response to bereavement, which 'confronts people with some of the most stressful adaptational challenges that humans experience' [6]. Where grief is complicated, it is said to be characterized by difficulty in

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functioning in work and in social relationships, a sense of meaninglessness, prolonged yearning for the deceased and disruption in personal beliefs. It also carries an increased risk of depression, generalized anxiety and panic disorder, alcohol abuse and use of medications, sudden cardiac events and suicide [7, 8]. Yet loss and change over the life course are intrinsic to the human condition, and grief responses can be triggered by a wide variety of circumstances and events, not just bereavement. The timing and nature of events can either support or disrupt the expected flow of life across age stages [2, 4]. For example, particular individual experiences of loss may result from broken or damaged relationships such as divorce; abuse; illness; disability (chronic or acute); disappointment in unfulfilled ambitions, e.g. childlessness; and bereavement through traumatic or untimely death [9]. All of these experiences occur within a wider social, economic and political environment which itself may provide supportive and fulfilling life opportunities or may generate other losses such as poverty, poor housing or unemployment [10, 11]. Acquiring a capacity to cope with significant life changes demands an acceptance of the implicit losses and the feelings associated with them along with appropriate adjustment to altered social circumstances. Evidence of effective coping demonstrates resilience and is characterized by positive self-esteem, courage, flexibility, optimism and finding meaning within the experience of loss and change (see Fig. 3.1) [9].

For older people, loss and change will have shaped past experience, and current losses may be multiple and complex, in particular the prevalence of ill-health and long-term conditions increases with advancing age [12]. Such loss experiences may promote psychological and behavioural competence within an individual or be accrued as unresolved developmental tasks [13].

Fig. 3.1 Ageing well with loss

3.2 The Challenge for Practice

Losses such as these have potential implications for mental health as individuals react to them and seek to cope with their consequences. The Mental Health Strategy for England (2011) emphasizes the importance of addressing mental health problems, particularly when these are co-morbid with physical health problems [14]. Having a long-term condition can bring with it various losses, and depression and anxiety are more common in such individuals for whom it worsens the prognosis, and psychological health outcomes and adversely affects overall quality of life [15–17]. Depression and loneliness are strongly associated, and longitudinal work has reported loneliness as an independent risk factor for future depression [18, 19]. It is associated with a high degree of morbidity including poor physical and mental health/function and also with increased mortality, whilst those with adequate social relationships have a 50 % greater likelihood of survival compared to those with poor or insufficient social relationships [20–23]. Loneliness is often a consequence of bereavement, particularly in spousal bereavement or divorce, and loneliness and low social interaction are predictive of suicide in older age [24]. Loneliness is associated with increased health and social services utilization, with lonely people more likely to visit their GP and have higher use of medication, higher incidence of falls and increased risk factors for long-term care, including early entry into residential or nursing care [20, 25, 26].

3.3 Ageing Well in the Face of Cumulative Losses: The Range of Response to Loss Model

In the light of such evidence, and given the changing demography in terms of ageing populations (see Chap. 1), developing theoretical and practical frameworks that can both identify how an individual is dealing with loss and support them in the assimilation of inevitable, cumulative and complex losses into positive later life experiences, rather than them being accepted as an inevitable and negative consequence of ageing, is a critically important challenge. The Range of Response to Loss (RRL) model offers one such theoretical framework [9, 27]. The Adult Attitude to Grief (AAG) scale, which reflects the concepts in the RRL model, offers a tool for practitioners and patients to identify both core reactions and dominant coping responses in the face of loss(es) [9, 28] and consider the most appropriate intervention to enhance coping and improve outcomes.

The RRL model conceptualizes grief as a two-dimensional interactive process made up of, first, core reflexive reactions to loss and, second, coping responses made in the active management of loss and its consequences [29, 30]. In the RRL model, these dimensions are represented by a spectrum of contrasting characteristics (see Fig. 3.2).

Core reactions are represented on a spectrum of a state of being *overwhelmed* in which the distress of grief is dominant to a *controlled* state in which the instinct to suppress expressions of grief dominates. *Coping responses* can be seen in a range from vulnerable to resilient. Most people will be vulnerable immediately after a significant

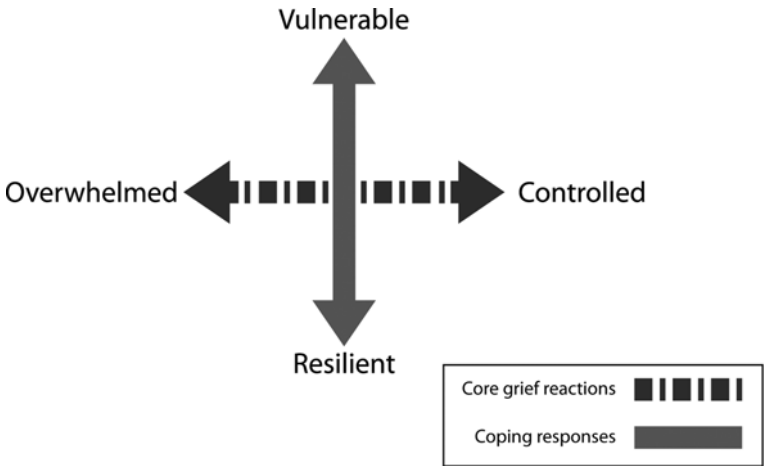

Fig. 3.2 The interacting dimensions of the range of response to loss model

loss as their own resources and those of supportive others may not yet be operationalized. However, when there is an increased capacity to acknowledge and accept those things which are irreversibly changed and those things which can be actively pursued in managing the loss and its consequences, living well with loss becomes possible.

3.4 Developing a Practice Tool: The Adult Attitude to Grief Scale

The AAG self-report scale provides a clear profile of the overwhelmed or controlled grief reactions and the vulnerable or resilient responses to loss (see Table 3.1). The scale consists of nine items devised to test the validity of the categories initially making up the RRL model – overwhelmed, controlled and balance/resilience. The items are scored on a Likert scale of 5 categories from 'strongly agree' to 'strongly disagree'. In addition to supporting the factor structure of the RRL model, research suggested the practical potential of the AAG, based on its capacity to profile the combination of factors unique to an individual and their experience of grief and its face validity for both practitioners and patients [9, 31].

With the development of the RRL model to include vulnerability as the spectrum opposite to resilience, research validated the use of the AAG to calculate an indication of this new component, by reversing the resilient item scores and adding them to the overwhelmed and controlled item scores, gives a range from 0 to 36: $O + C \quad R = V$ [28]. The research determined statistically the optimum cut-off scores on the scale for the classification of different levels of vulnerability:

Severe vulnerability	>24
High vulnerability	21–23
Low vulnerability	<20

Table 3.1 Adult attitude to grief scoring and comment sheet

Client number		Date		Session number		
Vulnerability indicator scores: R = Resilient C= Controlled O = Overwhelmed						
Adult attitude to grief scale	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**Additional responses/ comments**
R 1. I feel able to face the pain which comes with loss	0	1	2	3	4	
O 2. For me, it is difficult to switch off thoughts about the person I have lost	4	3	2	1	0	
R 3. I feel very aware of my inner strength when faced with grief	0	1	2	3	4	
C 4. I believe that I must be brave in the face of loss	4	3	2	1	0	
O 5. I feel that I will always carry the pain of grief with me	4	3	2	1	0	
C 6. For me, it is important to keep my grief under control	4	3	2	1	0	
O 7. Life has less meaning for me after this loss	4	3	2	1	0	
C 8. I think its best just to get on with life and not dwell on this loss[a]	4	3	2	1	0	
R 9. It may not always feel like it but I do believe that I will come through this experience of grief	0	1	2	3	4	

[a]Modified 2013 (resilient scores reversed to allow for a simple addition) Vulnerability indicator scores = total score for the 9 items

Additionally, cross-tabulation of the AAG scores with the demographic and clinical research data provided an indication of the characteristics associated with severe and high vulnerability. The following key factors were identified:

- Age under 25 and over 76
- Loss of a child
- Grief reactions: inability to accept the death, powerful distress/despair and difficulty in day-to-day functioning
- Coping responses: difficulty dealing with one's own feelings and difficulty dealing with the meaning of loss
- Complicating factors: mental health problems and financial problems
- Social factors: isolation

These findings are consistent with established risk factors for morbidity and mortality in grieving people and link with other specific studies relating to mental health issues in later life [32].

3.5 Implications for Practice

Widening access to appropriate mental health care is a public health policy priority in the UK [33]. However, a major concern in the study of grief throughout most of the twentieth century has been with the complicated psychological consequences of bereavement [34–39]. More recently the focus has moved to recognition of the huge variability in grief reactions and evidence that the majority of grieving people demonstrate resilience and satisfactorily adjust to loss [40–42]. This rise in positive psychology has provided a less pathological perspective on grief and one which suggests that resilience is more universal than previous theories of grief might have suggested [43, 44]. The focus on resilience within the RRL, therefore, not only gives a less pessimistic view of loss and grief but an important therapeutic focus when addressing vulnerability. These are hugely encouraging factors when thinking about loss in later life.

'The family physician is the only specialist who, through his or her position in the health system and in the community, can give emotional support to the bereaved and simultaneously deal with the health problems associated with the process' [45]. This is true of non-bereavement losses also. Moreover, failure to intervene appropriately with those who are most vulnerable results in an increased demand for health and social care resources, and mitigating the negative outcomes of loss and bereavement is, therefore, a significant issue for public and personal health [8]. Finally, recent review of the literature highlighted the importance of ensuring that more intensive interventions are targeted at those with greatest need and who are most likely to benefit [46].

Matching health and social care resources to individual loss needs requires careful assessment and review. At the time of writing, the Patient Health Questionnaire and the General Anxiety Disorder scale are commonly used in primary care in the UK to assess the severity of depression and anxiety, respectively [47, 48]. Whilst depression

and anxiety can be important consequences of loss, neither of these scales captures the individual expression and experiences of grief more widely evident in bereaved people. Current research and practice experience suggest that the AAG offers practitioners a concise and easy-to-use tool that does exactly that, and, in doing so, both empower patients (by offering insight) and enable practitioners to target appropriate resources to those most in need. Moreover, it facilitates the comprehensive, holistic person-centred approach to care that has been identified as best practice [49]. Given the growing population with more complex needs and the importance of tailoring interventions to meet the individual needs and preferences of patients, the full range of support available should be considered, from voluntary sector befriending and social interventions to specialist mental health services [50, 51].

3.6 Practice Audit

To remain responsive to diverse and changing populations of older people, we need to understand how our existing services can better tailor mental health treatments. With that in mind, a number of audit opportunities present themselves:

- Using the AAG to facilitate practitioner-patient dialogue and understanding of the impact of particular loss(es)
- Using the AAG as a baseline from which to identify vulnerability and refer onto other services
- Follow-up use of the AAG to indicate change over time and establish whether the intervention has resulted in increased resilience
- Identifying the acceptability of the AAG to patients
- Identifying the acceptability of any resulting referral intervention to patients and what other sources of support might be helpful

3.7 Next Steps

Whilst bereavement is associated with significant morbidity and mortality, the evidence on which health and social care practitioners can base their practice remains limited [52]. The situation holds true also when working with older people experiencing multiple losses, of which bereavement may be just one. Existing practice use of the AAG scale suggests that it is simple to use and has face validity, i.e. patients are able to relate their own grief to the items in the scale and experience it as providing some normality for the sense of emotional and mental turmoil generated by their loss [31]. It has the potential to provide practitioners with a tool able to distinguish those most in need of support either within the context of primary care or for referral on to other services, as well as identifying change over time. Interest and enthusiasm for the model and the scale have been reflected in their adoption in palliative and bereavement care contexts and in the recognition given to their contribution to contemporary theories of bereavement needs assessment [53–55].

Supported by the expertise of CORE Information Management Systems (CORE ims)[1] in routine outcome measurement, plans are being made for the wider use of the AAG. Part of this cooperative development with CORE aims to establish a learning collaborative across the bereavement care sector as the catalyst and context for further research and enhanced professional practice. It is anticipated that a learning collaborative will contribute to a growing evidence base on the use of the AAG in a wide variety of settings and amongst different population experiences a range of losses.

In reflecting the concepts in the RRL model, the AAG provides a profile of the psychological distress prompted by the loss(es) experienced, identifies the possibilities that may positively counter any negative consequences and can provide the basis for exploring the resources needed to face the pain and harness of such possibilities. By recognizing that grief is not only a reaction to loss but is a process of actively coping with its consequences, the RRL, and with it the AAG, points to the multi-factored possibilities for living well with loss.

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[1] CORE ims is a not-for-profit leader in the field of routine outcome measurement in mental health psychological therapies, which delivers and supports validated, reliable routine measurement tools (http://www.coreims.co.uk).

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